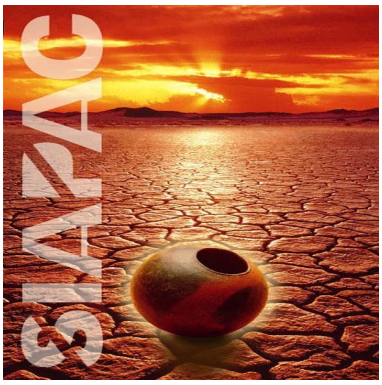

Final Report

Volume 1: Summary Report

Impact Assessment of HIV/AIDS on the Municipalities of Ongwediva, Oshakati, Swakopmund, Walvis Bay and Windhoek

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for
Family Health International (FHI) and the municipal authorities of Ongwediva, Oshakati, Swakopmund, Walvis Bay and Windhoek, on behalf of USAID/Namibia

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Chapter 1: Introduction

The HIV epidemic is affecting every aspect of Namibian society. These impacts include, among others, a reduction in the population growth rate, alterations to the demographic structure of the population, economic losses through a reduction in Gross Domestic Product (GDP), as well as broader societal change as the nation comes to terms with its losses, and the need to care for the infected and the affected. Paralleling these national impacts are severe impacts on households and extended families who help care for the sick and look after the children who remain behind. Economic and food security of infected and affected households is being undermined, while breadwinners are dying, and coping strategies are under unprecedented strain.

While the need to respond to the epidemic places considerable burdens on regional and local authorities in terms of implementing effective responses to the epidemic, their ability to do so is undermined because it is taking place within the context of direct impacts on the local authorities as well. The local authorities will lose personnel to the epidemic, due to illness, death, or responding to the illness and deaths of immediate and extended family members. Further, HIV/AIDS will increase the costs of doing business, and will effectively undermine the efficiency of the private sector and reduce turnover, with negative impacts on employment potential and creation of tax revenues. Local authorities are therefore playing a central role in preventing and coping with the epidemic, while they themselves are directly affected in a variety of ways. This means that a workplace programme for municipal employees needs to be complimented by effective outreach to support, coordinate and monitor the expanded municipal response to HIV and AIDS.

This Impact Assessment has examined the impacts of the epidemic on the five Namibian cities of Windhoek, Walvis Bay, Swakopmund, Ongwediva and Oshakati. This summary report forms the first volume of the study. It provides information on the context in which the five local authorities operate, background to the study and its methodology, as well as presenting integrated findings across each of the five participating cities and towns. Subsequent volumes (volumes 2-6) present detailed findings, specific to each participating city/town. Volume 7 contains a number of appendices.

Structure of the Report

This volume, Volume 1, provides background information and summary data from each of the five cities. In the remainder of this chapter, background and contextual information is provided, as is information on local authorities in the country, and details regarding the methods utilised in the investigation. Chapter 2 provides background information to the study itself, while Chapter 3 gives a summary of findings from the impact assessment. Finally, Chapter 4 summarises conclusions and lessons learned.

HIV/AIDS In Namibia

Overview

Despite the considerable gains made in overall quality of life, economic development, and health status, HIV/AIDS will lead to a decline in the overall health and economic status of Namibians. Namibia is among the world's worst-affected country in terms of HIV/AIDS, with a 2002 rate of 23.3% among pregnant women. Botswana is the worst-affected, at 38.8%, followed by Lesotho at 31%, Swaziland at 25.3%, and Zimbabwe at 25.1%. More detail is provided in the following table:

Table 1.1: Countries Worst Affected by HIV/AIDS (2001)

		People Living with HIV/AIDS		
Country	Population	Adults & Children	15-49 Adults	% Adult HIV Prevalence Rate
Botswana	1,592,000	330,000	300,000	38.8
Lesotho	2,006,215	360,000	330,000	31.0
Swaziland	981,000	130,000	120,000	25.3
Zimbabwe	11,509,000	1,500,000	1,400,000	25.1
Namibia	1,826,854	230,000	200,000	23.3 (2002)

Source: UNAIDS (2002).

The epidemic in Namibia is driven by a number of factors, including a history of dispossession, the diversity of its populations and cultures, internal migration and mobility. This has resulted in wide variation between the various regions and an epidemic which is at various stages (emerging, levelling off or rapidly expanding) in different areas. HIV prevalence rates for Namibia and selected sites in the years 2000 and 2002 are indicated in the following table:

Table 1.2: HIV Prevalence by Sentinel Sites (2000 and 2002)

Sentinel Sites (and Region)	HIV Prevalence (2000)	HIV Prevalence (2002)
Katima Mulilo (Caprivi Region)	33%	43%
Oshakati (Oshana Region)	28%	30%
Windhoek (Khomas Region)	31%	27%
Walvis Bay (Erongo Region)	28%	25%
Otjiwarongo (Otjozondjupa Region)	18%	25%
Rundu (Kavango Region)	14%	22%
Swakopmund (Erongo Region)	22%	16%
Keetmanshoop (Karas Region)	17%	16%
Gobabis (Omaheke Region)	9%	13%
Mariental (Hardap Region)	10%	12%
Rehoboth (Hardap Region)	9%	10%
Opuwo (Kunene Region)	7%	9%
Namibia	22.3	23.3

Prevalence rates are highest in Caprivi Region, where the epidemic was established at an earlier date than other regions, followed by Oshana Region (where Oshakati and Ongwediva are located), Khomas Region (where Windhoek is located), and Walvis Bay in Erongo Region. The increase in Khomas Region has been most dramatic, from 4% in 1992, to 7% in 1994, to 16% in 1996, to 23% in 1998, to 31% in 2000, but the figures for 2002 suggest that the prevalence rate may be stabilising. For Oshana, the growth has been almost as dramatic, followed by Erongo Region. However, both Walvis Bay and Swakopmund in Erongo Region show a drop from 2000 to 2002, with may signal a change in the direction of the epidemic in some areas. Nevertheless, because of error rates around the seroprevalence survey data, it is uncertain whether these trends are simply errors in measurement for either or both years, or signal actual changes. More information is required in this regard, either from additional seroprevalence survey findings or, ideally, from other approaches to assessing HIV prevalence (e.g., population-based surveys). Once these new data are available, prevalence could be worked into revised estimates for each of the five cities/towns. It should also be noted that the overall national trend is still increasing, and is still consistent with modelling findings.

AIDS has already had a significant impact on population growth rates, with the population previously expected to grow at 3.1% per annum between 1991 and 2001, instead growing at 2.6% per annum. While the population would have been expected to grow to 3.5 million by 2021, projections now suggest that the growth will be to 2.6 million (MOHSS, 2000). The crude death rate for Namibia is expected to more than triple due to AIDS, rising to 19/1000 by 2006, well above the expected level of 5/1000. Infant mortality is expected to be 59% higher with AIDS than without AIDS, while child mortality is expected to be double due to AIDS, despite enormous advances made in child health. Life expectancy gains that have been made since independence have already been reversed, and is

expected to fall from a high of almost 61 years to a low of 40 years by 2005, levelling at 46 years through 2021. According to the projections, the average reduction in life expectancy will be 24 years. The average annual population growth rate will decline to 1.4% between now and 2021.

Namibia is, therefore, already severely affected by HIV/AIDS, and this is set to worsen. This has taken place in the context of poverty, high levels of inequality in income status and access to resources, and in the context of a high percentage of female-headed households, and a high percentage of households with members living long distances from each other. Under these conditions, the vulnerability of many to HIV infection is high, and the ability to cope with the consequent effects is undermined. As of 2002 it is estimated that there are a total of 98,230 orphans, of whom 61,380 are AIDS orphans, and 36,850 are orphans from other causes. By 2021 there will be an estimated 190,000 AIDS orphans living at that time (defined as children under the age of 18 who have lost one or both of their parents) and 53,654 orphans from other causes (giving a total of over 250,000). The burden of looking after these children has fallen largely on the shoulders of extended family members, particularly grandparents and aunts (SIAPAC, 2002).

Response to the Epidemic

To respond to this national challenge, Namibia created the National AIDS Control Programme at independence. However, with growing recognition of the multi-sectoral nature of the epidemic, the institutional framework underwent significant restructuring, led by the National AIDS Co-ordination Programme (NACOP), launched in early 1999. A National AIDS Committee was formed, co-chaired by the Minister of Health and Social Services and the Minister of Regional and Local Government and Housing, the latter reflecting the decentralised approach to the problem. The Committee is comprised of all ministers, and serves as the key policymaking body on HIV/AIDS. The National Multisectoral Committee on HIV/AIDS (NAMACOC), chaired by the Permanent Secretary of the Ministry of Health and Social Services, includes all thirteen regional governors, all permanent secretaries, as well as NGOs and representatives from the private sector. Its focus is on policy and programme implementation. The National AIDS Executive Committee (NAEC), chaired by the Under Secretary of the Ministry of Health and Social Services, acts as the key implementing agency. There are Regional AIDS Committees in each of the thirteen regions, chaired by the Governor. In some regions, there are also District or Consistency AIDS Committees, although this is not common. The regional and sub-regional committees vary in size and composition, and in terms of activities and level of activity.

The above is taking place within the context of the second Medium Term Plan for the National Expanded Response to HIV/AIDS, covering the period 1999-2004, which was launched by His Excellency the President, Dr. Sam Nujoma. This Plan has recently been evaluated, and Namibia is preparing the way forward for activities from 2005 onwards.

Local Government

There was early recognition that a decentralised response to the epidemic was key to success. The strong representation of the Ministry of Regional and Local Government and Housing in the co-ordinating structures reflects the Government's commitment to a decentralised response, and the need to ensure the effective implementation of the expanded response through regional and local authorities, and regional and local initiatives.

In the context of this Assessment, local government refers to the management of the affairs of the participating cities and towns by their respective councils. As such they fall under the jurisdiction of the Ministry of Regional and Local Government and Housing (MRLGH) which administers the Local Authorities Act of 1992 (Act 23 of 1992), as amended in 2000 (Act 24 of 2000). These define the powers, duties and functions of local authorities and regulate their roles and responsibilities.

The scope of the Act means that each of the five authorities participating in this Impact Assessment have similar functions and management structures. Municipalities and towns are defined as areas with approved townships under the Township and Division of Land Ordinance (Ordinance 11 of 1963). Municipalities and towns thus have defined boundaries, and the land within these areas, unless alienated by title to property owners or having other defined uses (e.g., set aside as public open space, or for churches, schools or other institutions), fall under the control of the municipal or town council.

The Act provides for municipalities, towns and villages, each of which is defined as a local authority. In the context of this Impact Assessment, Windhoek, Walvis Bay and Swakopmund are municipalities, while Ongwediva and Oshakati are defined as towns, and all are defined as autonomous bodies. The major difference between a municipality and a town in terms of the Act lies in the extent of their ability to assume financial liabilities. In this instance, municipalities are regarded as fully autonomous and responsible for all financial obligations, while towns may receive financial assistance from Government or regional councils in meeting their financial obligations. For

both councils and municipalities, however, the Minister is required to approve loans and debts before these are incurred and to receive annual audited accounts through the Auditor General.

Both municipalities and towns have councils, democratically elected every five years. In the case of municipalities, the number of elected councillors may be between seven and twelve members. Each of the three cities participating in this study has ten. Town councils may have between seven and ten elected members; both Ongwediva and Oshakati have seven-member Councils.

Each local authority is required to have a management committee, elected from among its councillors, which is responsible for ensuring that council decisions are implemented and controlling financial expenditures and estimates in accordance with council decisions and the provisions of the Local Authorities Act.

Local Authority Structures

The structures of the five authorities, although similar, vary in complexity depending on the size of the community being served and the nature of the services provided. Nevertheless, despite differences, each is headed by a Chief Executive Officer (formerly Town Clerk) and the structure of each local authority includes departments (or combinations of departments) responsible for finance, administration, planning, engineering (which may be split into water, roads and electricity departments), community services, human resources, etc.

Services

The Act defines the services to be provided by both municipalities and towns and their responsibilities in managing these. Services to be planned for and provided by municipalities and councils are defined by the Act (as well by other relevant legislation such as the Water Act) and may include the following:

- Water
- Electricity
- Public Safety
- Housing (including the development and sale of serviced land)
- Urban streets and roads
- Public Transport
- Cemeteries
- Sewage and drainage

All these urban services are to be provided by local authorities on a full cost recovery basis. Service delivery standards vary based on assessments of affordability within each municipal area but range from full service with indoor connections to communal sanitation and water. In the case of basic services, such as water and electricity, NamWater and NamPower are the companies with national responsibility for these services, and provide bulk supplies for the local authorities to distribute the service throughout the urban area. The three cities of Windhoek, Walvis Bay and Swakopmund purchase water and electricity in bulk and distribute and sell the service to their residents. In Oshakati and Ongwediva, water is purchased in bulk and the Town Council is responsible for its distribution and sale. Electricity distribution is outsourced to private companies in which the two town councils of Oshakati and Ongwediva have shares.

The provision of other services is funded through assessment rates levied on all immoveable property within a local authority's boundaries and the Act provides that each may establish its own rates provided these are gazetted annually. In some instances these other services may be outsourced, such as refuse collection in Ongwediva or the abattoir in Swakopmund.

Other services, including those such as health and education, remain the responsibility of central government, and their provision is planned by the National Planning Commission (NPC), with the relevant national ministry then being responsible for their construction, staffing and operation. Local authorities can request provision of these services, but the NPC and the responsible ministry then decide if these are indeed needed and have the authority to locate them according to national planning parameters.

Planning and Budgeting

Local authorities work to a Structure Plan that determines the zoning and planning layout of the town. They determine residential, industrial, recreational and public open spaces and street layouts, etc. These plans generally have a ten to twenty year horizon and will indicate where urban growth is anticipated and where service delivery may be required over this timeframe.

The municipal budget process works to a two or three year horizon for the five local authorities participating in this Assessment. These budgets cover capital and operating expenditures and forecast revenues from rates, the sale of services and land, as well as investments. In the case of capital budgets, central government funding, loans and donor funding are also considered.

Development Challenges

As is the case elsewhere in the region, local authorities in Namibia are facing major challenges in developing their municipalities and towns. Among these problems are rapid urbanisation, unemployment and the need to provide adequate shelter for their growing populations. Cutting across each of these challenges is the impact of HIV/AIDS.

Urbanisation and Employment

Unfortunately no urban-rural data have been provided at this time from the 2001 census. However, calculating the urban population from population figures for those areas marked as urban (which includes some rural areas surrounding smaller municipal areas, such as Tsumeb and Grootfontein), it is estimated that some 32.4% of Namibia's population live in urban areas. This is well below estimates made in 1996 (Pendleton and Frayne, 2000), where it was estimated that 35% were already living in urban areas in 1996, which would have risen to over 40% by 2001. Nevertheless, 'push' and 'pull' factors leading to urban migration are still very strong.

Namibia has a high rate of urbanisation, and the push and pull factors that have supported this urbanisation are difficult to counter.

In the north of the country, where over 60% of the population live, economic activity is largely based on small enterprises, local trade, livestock rearing and, to a lesser extent, arable agriculture. These activities do not meet the full livelihood needs of household members, while Namibia's productive natural resources such as mines, industries, commercial agriculture, etc., are in the south and centre of the country. Equally, urban areas are seen as providing improved access to social services, such as health and education.

The population of Windhoek, the capital of Namibia, grew at an annual rate of 5.4% between 1991 and 1995, the largest annual growth rate in its history. Of this, net migration is presumed to account for 3.9% of the annual growth rate (TRP, 1996). Other urban areas exhibiting rapid growth include Walvis Bay (following its re-incorporation into Namibia in 1994), and to a lesser extent Swakopmund. In Walvis Bay, growth was driven by migrants in search of jobs generated in large part by the expansion of the fishing industry. Anecdotal evidence now suggests that Walvis Bay is growing as rapidly, or faster, than Windhoek, while Erongo Region's high growth rate is likely due principally to in-migration to Walvis Bay.

With a high dependence on wage income, Namibia's unemployment rate of 34.8% is of particular concern (the unemployment rate includes those actively seeking work as well as those not actively seeking work, referred to as the 'broad' definition). Focusing specifically on those who are actively seeking work (the so-called 'strict' definition), the unemployment rate as of 1997 was 19.5% (MOL, 2001). Those actively seeking work tend to cluster in urban areas where jobs are more likely to be found, resulting in 'imported' unemployment, giving higher rates of strict unemployment than rural areas (23.8% for urban areas and 15.6% for rural areas). As a result, the difference in broad unemployment rates across urban and rural areas is fairly small (36.4% for rural areas, 32.5% for urban areas). Broad unemployment in Khomas and Erongo regions is lower than the national average, at 29.1% for Erongo Region and 30% for Khomas Region. The rate is higher in Oshana Region -- which tends to 'import' those actively seeking work from the surrounding regions -- at 38.9%. Perhaps not surprisingly, broad unemployment rates are higher for women than men, at 40.5% for females compared to 29% for males.

Urban areas tend to draw in job seekers in numbers well beyond the number of jobs being created. Unemployment rates in urban areas are over 8% higher than in rural areas, with many of those unemployed and actively seeking work coming from rural areas. This affects all five municipalities in this investigation.

The bulk of Namibia's industrial base is located in the central part of the country, largely in Windhoek and Walvis Bay, while mining activities are concentrated in the central, western, and southern parts of the country. Walvis Bay is heavily reliant on the fishing industry, a sector that suffers from considerable annual variation depending on fishing stocks. Neighbouring Swakopmund relies heavily on the tourism sector, as well as on the mine at Arandis, some sixty kilometres inland from Swakopmund. Windhoek has a more diversified economy, including the government sector, manufacturing, services, and transport. Oshakati and Ongwediva, by contrast, have a fairly small industrial base, with a heavy concentration of retail enterprises.

Housing

Namibia uses the United Nations definition of housing, which includes the dwelling unit and services, the level of which is dictated by affordability. Government's role (through the MRLGH) is to facilitate the provision of housing in partnership with the local authorities (among other partners, including the private sector).

In the larger urban areas, the challenge is to overcome the distortions in provision of shelter resulting from the discriminatory and racially biased policies of the past (among which are segregated housing developments, including single quarter hostels for migrant workers) while simultaneously meeting the housing demand created by increasing migration and urbanisation. In order to meet these challenges, several national housing policies and strategies are in place. They include:

- The Build Together Programme, which provides loans to low income groups and individuals and residents for single quarters to purchase plots and build houses.
- The National Housing Enterprise which loans to all income groups at market rates and provides loans to single quarters residents to purchase the units.

In addition, several of the towns participating in this Impact Assessment have their own housing funds and strategies, such as the Windhoek Housing Fund or the recently completed Monduletu Housing Project in Swakopmund, funded by donors. For those who cannot afford to purchase land and housing, several cities provide vacant serviced plots for low monthly rentals, which can be purchased over time. However, the delivery of adequate housing continues to be constrained by inadequate financing and increasing demand for affordable shelter, which is likely to continue for the foreseeable future. How AIDS can affect service delivery and demand, in this regard, is not certain.

Decentralisation

The Government of Namibia is in the process of decentralising powers and responsibilities to the country's thirteen regions and to local authorities. Decentralisation is a requirement of the Constitution of the Republic, while the Local Authorities Act gives partial effect to this provision.

The Government's decentralisation plan provides a list of sixteen functions which are to be decentralised to the local authority level, among which include primary health care, social services, community development, early childhood development, youth, sports and recreational activities, and other areas.

Decentralisation is to be phased in based on scheduled plans which are themselves based on the authority's readiness and capacity to manage functions. These plans have been developed by MRLGH which is the lead agency in the decentralisation process. Funding for the increased responsibilities of local authorities will be provided in part by central government while some will be derived from their increased ability to raise revenue at the local level (e.g., through vehicle registration and licensing, water rates, etc.). However, the intended planning and phasing of

decentralisation to local authority level remains unclear. The Khomas Regional Development Plan for the period 2001/2 to 2005/6, for example, states that primary health care will be decentralised to Windhoek Municipality by 2003/4, but makes no mention regarding how this handover of responsibility from the centre will occur.

While decentralisation will serve to link local authorities more effectively to the communities they serve, it will also pose an additional development challenge, in that it will bring with it additional institutional development, delivery capacity and financial needs.

Other Role Players

Within the local government arena in Namibia there are other role players that variously have some involvement in the professional development of local authorities and their officers, assist in service provision, and undertake development projects (some of which relate to HIV/AIDS). These include the National Association of Local Authorities Officers (NALAO), the Association of Local Authorities of Namibia (ALAN), the Shack Dwellers Association and the Housing Action Group (which is the umbrella organisation for the Shack Dwellers Association). The National Association of Local Authorities Offices (NALAO) is a professional association of staff members of all local authorities in Namibia (including village councils). As a membership organisation, it provides a platform through which the staff of local authorities can come together to discuss and confront the development challenges facing local administration. The Association views itself as a professional body and includes among its objectives the following:

- to identify and meet education and training needs in local government;
- to serve as the advocacy arm of local government professionals and to promote their interests;
- to promote ethical and professional standards among local government administrators and managers.

NALAO is involved in various projects and activities, one of which is to provide support to local authority responses to the HIV/AIDS epidemic. It is therefore envisaged that the results of this Impact Assessment will be used to develop a response to the epidemic among other local authorities in Namibia through NALAO.

The Namibia Housing Action Group (NHAG) was established in 1999 as a support service to community-based housing. In this regard it provides support to the Shack Dwellers Federation of Namibia. This latter group organises community savings schemes in order to allow those participating to acquire affordable land and resources. Some twenty groups involving more than 1400

households have obtained land in this way through negotiations with local authorities. They have offices in Windhoek and Oshakati and groups operating in each of the five local authorities participating in this study. These organisations could be an important vehicle for expanded community outreach promoting HIV/AIDS activities.

Summary

The emergent commitment to decentralisation within the context of strengthening local authorities offers a supportive environment to linking local authorities to the people they serve. However, the local authorities, particularly in the north, suffer from shortages of resources to fulfil their mandates, and these problems will worsen due to HIV/AIDS. The Impact Assessments represent one way in which the local authorities can plan for these impacts.

Chapter 2: Background to the Study

Introduction

This chapter provides background information on the study, specifies its aims and objectives, and includes a brief discussion on the methodology used to complete the Impact Assessment.

Background to the Study

In 2000 the Chief Executive Officer of the Municipality of Windhoek initiated a process to consider the impacts of the HIV/AIDS epidemic on the municipality of that city, as well as the people it served. After discussions with counterparts in Walvis Bay and Swakopmund, the proposed investigation was broadened to include the two coastal towns as well, and was later further expanded to the two northern towns of Oshakati and Ongwediva.

Financing was sought for the impact assessments from the United States Agency for International Development (USAID), and provided via Family Health International, an international non-governmental organisation working in the HIV/AIDS arena. Technical support for the impact assessment was provided by Social Impact Assessment and Policy Analysis Corporation (SIAPAC) and was implemented by SIAPAC in conjunction with the Health Economics and HIV/AIDS Research Division (HEARD) of the University of Natal, Durban, South Africa and JTK Associates, a development consulting company located in Mbabane, Swaziland.

Aims and Objectives

The aim of the assessment was to provide detailed insights into the internal and external impacts of the HIV/AIDS epidemic on the five municipalities of Ongwediva, Oshakati, Swakopmund, Walvis Bay and Windhoek, as follows:

Internal Impacts

- the impact of HIV/AIDS on the personnel within the Municipality;
- on the ability of the municipality to meet its mandated responsibilities.

External Impacts

- on the businesses within the city;
- on health services;
- on the economic and social well-being of residents living within the Municipality;
- on the overall quality of urban life in the city.

Of equal importance, the assessment was intended to 'mainstream' HIV/AIDS into the functions of the municipalities. This was to be accomplished through the development of an HIV/AIDS strategy and action plan following review of this report by the respective local authorities.

Specific objectives of the assessment were as follows:

1. Project the demographic impact of HIV/AIDS illness and death on the population of local authority personnel, and indicate needed additional human resources.
2. Project the demographic impact of HIV/AIDS illness and death on the population living in the local authority areas.
3. Project the economic impacts of HIV/AIDS on households in the local authorities' areas and consider the impact this will have on affordability and payment for local authority services and the overall revenue base.
4. Project the economic impacts of HIV/AIDS on businesses in the local authorities' areas and consider the impact this will have on the viability of key business sectors.
5. Qualitatively assess the impact on 'quality of life' for the local authority areas (e.g., ability of households to meet basic livelihood needs, levels of crime, street children, etc.).
6. Consider the costs associated with HIV/AIDS prevention activities for local authority personnel. Compare this to the costs associated with not implementing the intervention. Outline possible programmatic interventions.
7. Outline an HIV/AIDS strategy and action plan.

Methodology

The study was divided into four phases: design; implementation; analysis and write-up; and planning/integration.

Design

Mobilisation

Start-up was delayed for several months due to various technical requirements, and work on the Assessment only began in September 2001 when all outstanding agreements were in place. Work began with a series of inception visits by the Deputy Team Leader, Mr. Mouton of SIAPAC, to all participating local authorities. The purpose of these visits was to brief local authority executives on the assessment and begin preparations for the Inception Workshop.

Inception

The Inception Workshop was held at the Safari Hotel in Windhoek on 7 and 8 November 2001. It was attended by participants from each of the participating local authorities, among them Chief Executive Officers and finance and human resource managers. The purposes of the workshop were to:

- introduce participants to the aims and objectives of the project assessing the impact of HIV/AIDS on five Namibian cities (Walvis Bay, Windhoek, Swakopmund, Oshakati and Ongwediva);
- to seek agreement on project aims and objectives with participants, following review and discussion; and
- to plan and agree to a schedule of work with representatives of each local authority.

These objectives were met during the workshop. In addition, participants recommended that an Advisory Group be appointed to guide the work of the consultants and local authorities during the Assessment, and suggested members to sit on the Advisory Group. Participants also agreed on the nature and type of information and data needed for the Impact Assessment that were to be supplied by the municipalities, and established a schedule for its provision. The Workshop minutes are included in Volume 7 of this report.

Following this workshop an Inception Report was submitted. This contained changes to the propose schedule of work because of the late start of the Impact Assessments (due to delays in getting all local

authorities on board and available at the same time), and the difficulties imposed by the pending Christmas break when few officers would be available to collect the requisite information.

Concurrent with data gathering activities was the completion of a detailed literature review. A bibliography is attached to this volume, and to volumes 2-6.

Following the literature review, and in addition to long-term dialogue and information gathering activities, qualitative data gathering instruments were developed to conduct interviews with municipal employees. Specifically, qualitative discussions were held with small groups of municipal officers. The aim was to gain insights into attitudes about HIV/AIDS and recommendations on how HIV/AIDS prevention activities should proceed within the local authorities. Two qualitative approaches were employed: 1) focus group discussions; and 2) story with a gap. These were supplemented with key informant interviews with municipal managers.

At the end of this Design Phase progress meeting were held (one in each of the five locations), at which time Progress Report 1 was submitted.

Implementation

Implementation consisted of three basic activities:

1) reviewing the information made available and analysing gaps in the data;
2) projecting HIV/AIDS impacts; and
3) implementing key informant interviews, focus group discussions, and story with a gap group discussion instruments.

As soon as the relevant data became available from the local authorities on their personnel, these were applied to projections of personnel numbers. The 1998 projections of the demographic impact of HIV/AIDS were updated by MOHSS to include 2000 seroprevalence data (using the SPECTRUM group of models), and these were used as the basis for projecting the impact of the epidemic on the five local authorities and the populations they serve.

The model required a great deal of demographic data in order to complete the projections. Data from the Central Bureau of Statistics (CBS) and the Ministry of Health and Social Services (MOHSS) were used, and the assumptions made were, to the extent possible, the same as those made for the national

projections on the demographic impact of HIV/AIDS. A more detailed discussion in this regard is included in Volume 7.

The data on local authority personnel and local populations were needed in a format that was both consistent and useable. These requirements were communicated to the local authorities, and during the initial start-up meetings the consultants provided the local authorities with a format for these data and agreed to a schedule for their provision. Most of the municipalities were able to comply but, despite everyone's best efforts, repeated delays were experienced in receiving these data.

Once the data became available, projections from the model were applied to the relevant local authority populations. For example, the model allowed for the projection of HIV prevalence levels and AIDS-related deaths among municipal staff by cadre. Similarly, it allowed the investigation of the demographic impact of the epidemic among the populations these authorities served, and allowed consideration of some assumptions about these impacts on the demand for services and the ability to pay for them.

To supplement the quantitative data and collect information on attitudes important for an understanding of potential impacts, two qualitative approaches were used: 1) Focus Group Discussions (FGD); and 2) Story With A Gap (SWAG). FGDs are particularly useful in collecting detailed insights into sensitive issues such as HIV/AIDS. SWAG is a variation on the FGD approach, and is a useful tool in getting participants to consider their current situation in relation to a desired state, and discussing roadblocks and needed actions to move from their current state to a desired one. For this consultancy, the two approaches were used so that respondents could consider how the local authorities might best respond to the epidemic.

At the end of the Implementation Phase further progress meetings were held in each of the five municipalities, after which Progress Report 2 was submitted.

Analysis and Write-Up

As data became available the impacts of HIV/AIDS on the local authorities were modelled. This took some time, given the complexity of the projections, particularly in relation to internal migration within Namibia, and given continued data gaps. The model does not easily accommodate internal migration effects, and assistance was sought from the developer of the model in this regard. In

response to requests from the Consultant, Mr. John Stover of The Futures Group kindly developed the bridging formulae needed to allow the model to incorporate internal migration.

Qualitative/participatory findings were compiled using NUD*IST, a data analysis software package designed to systematically interrogate qualitative findings, and thereafter the key findings were incorporated into the reports.

The report was then submitted for review by the municipalities and comments solicited. A final set of progress meetings was held with each of the five municipalities in order to present the findings from the draft report and facilitate receipt of comments and feedback.

Planning and Integration

Methodologies to integrate HIV/AIDS into the activities of the three local authorities, and to assist the five municipalities in prepare concise HIV/AIDS Prevention and Response Strategy and Action Plans, were developed at an advocacy workshop with the five local authorities. This was held in Walvis Bay from August 12 - 16, 2002. This planning workshop assisted the five local authorities to review and analyse the findings from the reports. Following this, participants began the process of planning for interventions intended to mitigate the impacts on the municipalities themselves, including prevention programmes intended to reduce infection rates among municipal personnel and the communities they serve.

Following the Action Planning Workshop, the reports were finalised in draft form for final circulation, incorporating comments and changes from the local authorities. These constituted the draft reports, and included the action plan and advocacy strategies developed at the closing workshop. These reports were thereafter finalised.

Chapter 3: Integrated Findings

Introduction

The impacts of HIV/AIDS on the five cities are considerable, not only because of the number of deaths and the resultant reduction in population growth rates in the communities they serve, but because those who are dying are in the productive or working age groups. The epidemic is, of course, nationwide, and it will likely worsen in-migration to the five cities. Unlike epidemics of the past, which targeted the weak, the very young and the old, HIV infects the sexually active population, with infection rates highest in the 25-35 year old age group. These are the workers and parents in any community and their loss has enormous long-term socio-economic consequences for society.

This Impact Assessment examined impacts across the cities of Ongwediva, Oshakati, Swakopmund, Walvis Bay and Windhoek. It projected the demographic impacts on each city in terms of the level of HIV prevalence, cumulative projected AIDS deaths and population growth rates, among other issues. Each of these will have important implications for municipal planning and service provision, but HIV/AIDS will also affect the economic performance of the city, in turn impacting on municipal revenue generation.

The challenge is that the epidemic erodes the ability of institutions, including local authorities, to provide services, as it reduces both efficiency and revenues, while the personnel losses induced by HIV/AIDS affect the quality of services provided. These impacts result from the sickness and death of municipal personnel infected with HIV, and can include:

- loss of productivity;
- increased absenteeism;
- cost of sick and compassionate leave;
- increased cost of benefits; and
- increased recruitment and training costs to replace lost staff members.

This Assessment examined these varied impacts, among others, which are discussed in detail for each city in subsequent volumes of this report. This section of the main report highlights key findings across the five cities, first presenting those affecting the general population (the external impacts), then examining the internal impacts on the municipalities and finally the economic impacts.

External Impacts

The external impacts of HIV/AIDS relate both to alterations in the demographic structure of the cities, and the social and economic changes resulting from these alterations.

Finding 1: HIV prevalence across the five cities is likely to peak over the next three to five years, and at very high levels.

Namibia undertakes antenatal sero-surveillance surveys of the HIV prevalence rate every two years. The last such survey was carried out in 2000, and the antenatal prevalence rates for the five cities are presented in the following table:

Table 3.1: Antenatal HIV Prevalence Rates (2000 and 2002)

City /Town	Prevalence Rate (2000)	Prevalence Rate (2002)
Ongwediva	28%	30%
Oshakati	28%	30%
Windhoek	31%	27%
Walvis Bay	28%	25%
Swakopmund	22%	16%
National	22.3	23.3%

Source: MOHSS (2000). Data for 2002 has not been fully released, but have been made available within the Ministry itself.

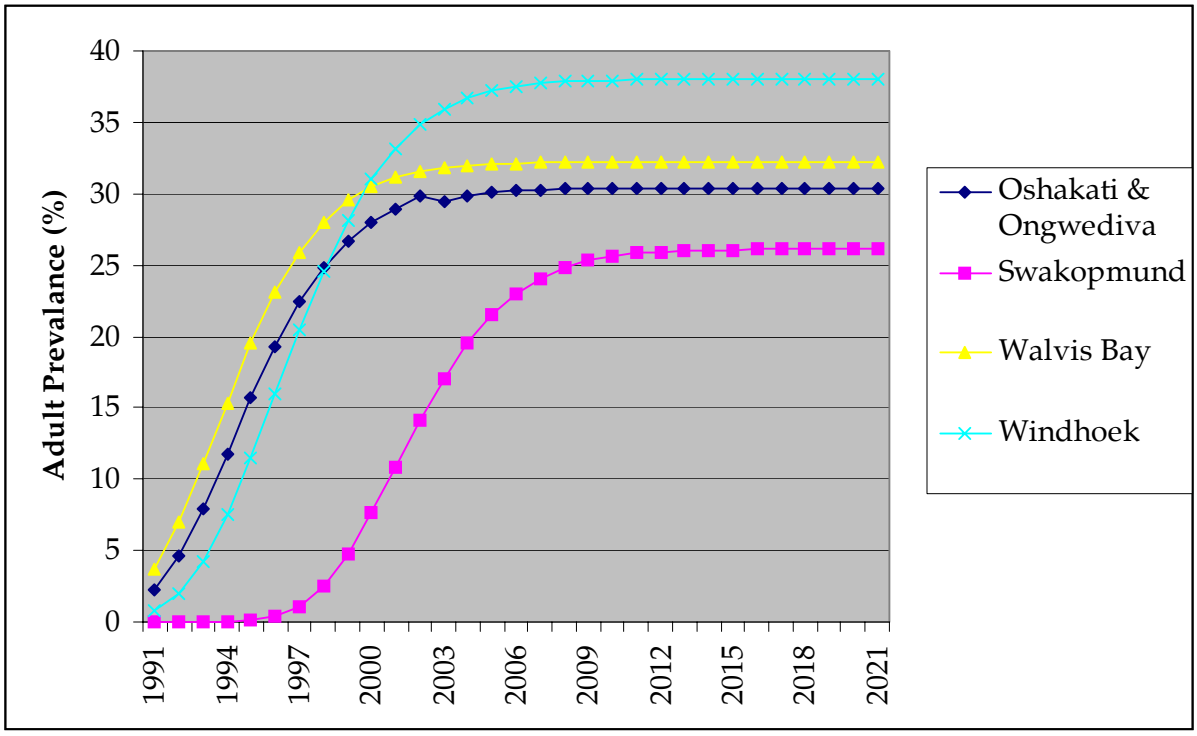
As noted in Chapter 1, the 2002 prevalence data do show some promise regarding the epidemic, if indeed they do reflect actual trends. Unfortunately, in past cases of similar drops the rates 'recovered' (e.g., Oshakati in 1998 and 2000), so more data will be required to see if the trends shown in Windhoek, Walvis Bay and Swakopmund are indeed trends, or statistical artefacts. The trends in Walvis Bay and Swakopmund do coincide with a reported drop in other sexually transmitted infections which, if not a reporting error, do show some promise.

Nevertheless, in responding to these figures, it is best to plan for more difficult scenarios. The projections for all locations here, for example, already may be conservative based on an assumption that national prevalence will level at around 25%, yet a number of neighbouring countries have not levelled off, and are now at rates considerably in excess of Namibia (e.g., Lesotho, Swaziland,

Botswana). Projections based on 2000 seroprevalence data may therefore be the most realistic, subject to revision upon receiving the results of the next seroprevalence survey or, better yet, population-based HIV prevalence data.

Prevalence rates will continue to rise over the next 3-5 years, at which point they will level off, with the exception of Swakopmund where prevalence is projected to level slightly later, at 26%, by 2009. In Windhoek, which has the second highest prevalence rate, the epidemic is projected to begin peaking in 2004/5 at just over 39%. In Ongwediva and Oshakati it is projected to peak at just over 30%, while in Walvis Bay it will peak at a higher 33%. This is illustrated, by city, in the following figure:

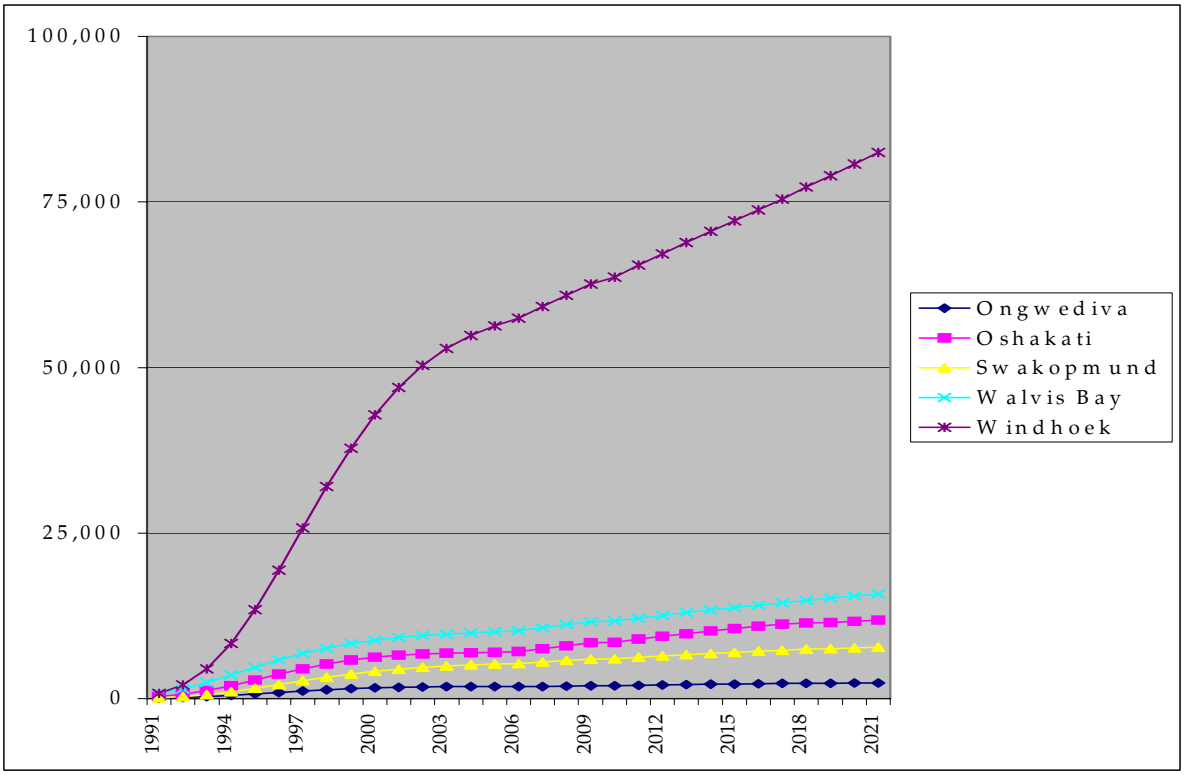
Figure 3.1: Projected HIV Adult Prevalence, 1991 - 2021



These high prevalence rates imply that almost one-quarter to one-third of the adult population (those aged 15 to 49+ years of age) in the five cities was likely to be infected in 2001. However, by the time the epidemic peaks, between 26% in Swakopmund to 39% in Windhoek of the adult populations in the five cities will be infected.

Figure 3.2 displays the number of people infected with HIV between 1991 and 2021. It should be noted that the populations of the five cities vary considerably, and that Windhoek is five times larger than Oshakati.

Figure 3.2: Number of People HIV Positive by Year, 1991 - 2021



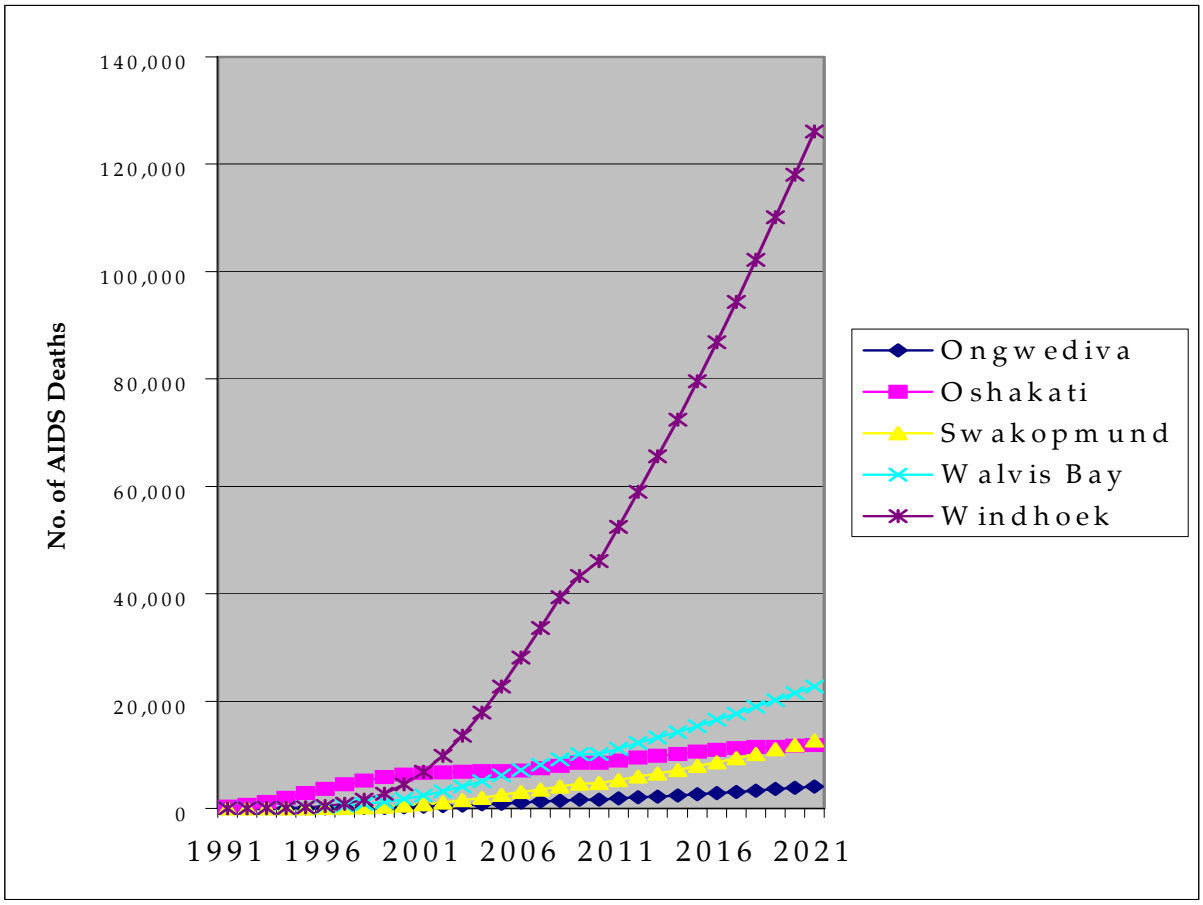
The data in Figure 3.2 suggest that, in 2001, there were some 47,000 individuals who were HIV-positive in Windhoek, over 9,000 in Walvis Bay, 6,575 in Oshakati, close to 4,500 in Swakopmund and over 1,700 in Ongwediva. These numbers are projected to increase by 2021 to over 85,000 individuals in Windhoek who are likely to be infected, close to 12,000 in Oshakati and 2,350 in Ongwediva.

Finding 2:	AIDS deaths from current HIV infections in the five cities will peak eight to ten years from now. These deaths cannot be prevented as they will result from current infections, but support programmes can assist those who are HIV positive to live productively and positively, prolonging their lives. Equally much can, and should, be done to reduce the projected AIDS death rate beyond 2012. for those who are not yet infected.

While HIV prevalence is close to its peak, the lag between infection and death means that the AIDS epidemic is a number of years behind. AIDS deaths are likely only to peak eight to ten years after HIV has peaked. Figure 3.3 presents projected AIDS deaths across the five cities over the period 1991 - 2021. By 2001, Oshakati will have already lost close to 9,000 people to AIDS, Windhoek some 52,500 people, Swakopmund over 5,300, while Walvis Bay will have lost over 11,000 residents and Ongwediva close to 2,000. Because of the lag time between HIV infection and AIDS death, there is little that can be done to prevent these deaths as they result from current infection levels. However, in the absence of treatment, it is important to note that creating a climate that destigmatises the disease, encourages positive living and the participation of those infected in wellness programmes can do much to prolong productive lives. In most of these municipal areas there are organisations that can assist; these have been indicated to the municipalities in the detailed reports.

Cumulative AIDS deaths are indicated in the following figure:

Figure 3.3: Cumulative AIDS Deaths, 1991 - 2021



By 2021 some 126,128 individuals are projected to have died of AIDS-related illnesses in Windhoek, close to 23,000 in Walvis Bay, over 12,500 in Swakopmund, close to 12,000 in Oshakati and over 4,000 in Ongwediva. This gives a total of 177,628. Of these, some 36,000 are already infected, and will eventually die. However, some 140,000 of the projected deaths will be from future infections. These can, and should, be reduced through the consistent implementation of prevention programmes, destigmatisation and other measures, including treatment, if and when such treatment becomes affordable. The central importance of treatment for those HIV positive should not be forgotten. As anti-retroviral therapy becomes more available and more affordable, the impacts of HIV on municipal personnel, households and communities can be significantly lessened. To be effective, this will require extensive workplace programmes within the municipalities, as well as expanded access within the communities to voluntary counselling and testing services, care and support. Anti-retroviral therapy is lifelong, and must be taken correctly every day, and this requires strong support.

Finding 3:	Population growth in the five cities will be reduced and their size will be smaller because of AIDS. Migration will likely increase among those in search of urban employment opportunities, therefore the cities will continue to grow, albeit more

slowly compared to trends during the 1990s. Unfortunately, it is also likely that the larger effects of HIV/AIDS will distort this migration as well, with in-migrants often being extremely poor and with low skill levels.

AIDS-related deaths will decrease the populations of the five cities in two ways. First, these deaths will directly affect the size of the populations of the five municipalities as individual residents die. Secondly, HIV/AIDS affects young adults. The death of young adults reduces the number of children born. This is because parents die before having the expected number of children. The population of the five municipalities will therefore grow at a slower rate than in the past, as its residents die, and as a lower than expected number of children are born.

It is expected, however, that all of the cities will continue to grow, albeit at a slower rate because of continued high levels of inward migration from other areas of the country. The population of Windhoek is projected to be some 22% smaller in 2011 than it would have been in the absence of AIDS and 34% lower by 2021. In Oshakati, the town's population will be 25% smaller by 2011 than it should have been without AIDS and 39% smaller by 2021.

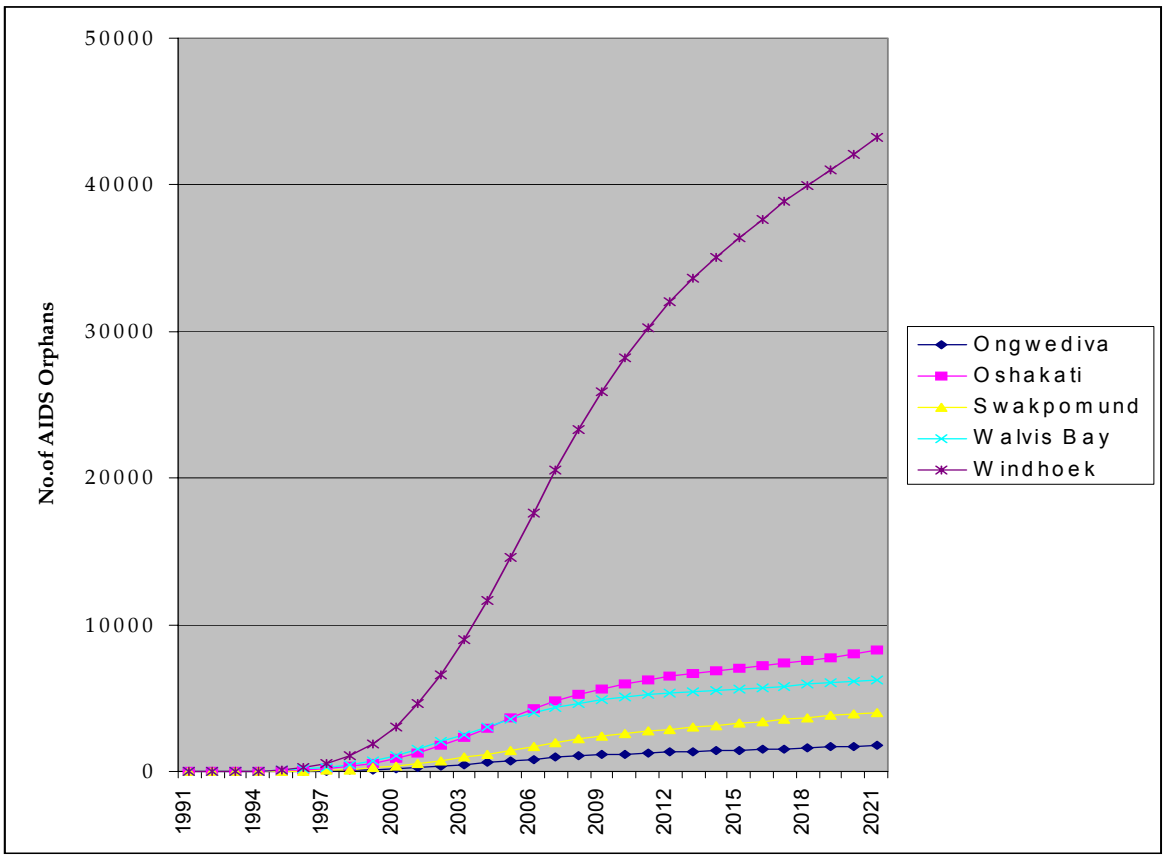
Similarly, reductions in the size of its population are anticipated in Ongwediva, while in Walvis Bay the population will be 23% smaller than it should have been by 2011, with a 34% reduction by 2021. Swakopmund's population is projected to be 16% smaller by 2011 than it should have been, and it will be 25% lower by 2021.

It should be remembered that, in considering impacts on the five municipalities, one should not forget that the interaction between these municipalities and rural areas is very strong, and HIV infected 'generated' in these municipal areas has a knock-on impact on rural areas. HIV prevention within the municipal areas, therefore, has a positive impact well beyond the borders of the municipalities, highlighting the key role municipalities can play in responding to the epidemic.

Finding 4:	There will be a significant increase in the number of orphans. Failure to provide appropriate and adequate care for children who have lost their parents has serious implications for their development and their long-term growth towards becoming productive, responsible members of any society. Problems arising from a 'lost generation' will most significantly impact urban areas, including those in the impact assessment.

Losses of adults in the productive age groups will leave many children in the city without parents. The following figure displays the rise in the number of children orphaned as a result of AIDS.

Figure 3.4: Projected Number of AIDS Orphans 1991 - 2021 (loss of mother or father or both)



A recent study on orphans in Namibia found that some of the children orphaned in the urban areas of central and southern Namibia were being sent to relatives in the north, while others remain behind (SIAPAC, 2002a). It is therefore likely that the projection overstates the number of AIDS orphans in Windhoek, Walvis Bay and Swakopmund, and understates those in Oshakati and Ongwediva. However, without household level studies, beyond the scope of the current Impact Assessment, this is impossible to quantify.

What can be said is that many children who fall outside of the reach of extended families employ other measures to build the semblance of a family environment, including involvement in groups of street children, gangs, etc. To date there are no organisations involved specifically in this arena (one organisation, the Velile Children's Trust based in Windhoek, has only just begun its activities and

lacks human and financial resources to provide much support). Levels of petty theft can therefore be expected to rise, as can levels of violent crime.

It is always 'best practice' to have children who are orphaned join other family members, or be taken in by neighbours in familiar circumstances. Indeed, the orphans study (SIAPAC, 2002a) found that this is largely what is happening. Institutionalisation is a last resort, but when it does happen it happens largely with children from urban areas. This underlines the fact that the support networks so important in rural areas is considerably weaker in urban areas. If rural-urban ties are weakened, more and more of these children will end up on the streets in major urban areas. Anecdotal evidence suggests that children who are raised in difficult circumstances are often at above-average risk of HIV/AIDS infection as well. Socialisation patterns have been distorted, and rules of behaviour is lacking. For many young girls in these circumstances, and for some young boys, the risk of sexual exploitation is considerable.

Finding 5:	The economic impact of HIV/AIDS will be felt throughout the five cities - by industries, by retail businesses and by households. Workplace programmes are important responses, coupled with the extensive outreach to households. Impacts on municipalities would be associated with a weakened economic base, as well as direct costs.

Businesses are directly affected by HIV/AIDS in two ways: 1) impacts on employees and management; and 2) impacts on the buying power of the public. In both respects, HIV/AIDS will have severe impacts. For many businesses, the loss of skilled and semi-skilled, experienced personnel will be especially devastating, while unskilled labour will generally be quickly replaced. Being able to effectively replace these people will be undermined by the costs associated with the loss of personnel (sick leave, pension monies, etc.), and the shortage of people with the relevant skills and experience. It will also be made more problematic by the wage distortions emergent in the marketplace as more and more employers are chasing fewer people with the requisite skills and experience. It may also result in a shift in industries towards lower skills levels, allowing rapid economic growth but of a very different nature that might ideally be desired (e.g., rapid growth in low-paid jobs in the textile industry).

At the household level, the economic capital of households is significantly undermined by the costs associated with the sickness and death of those who are lost to AIDS, and often by the loss of a (or the) key wage earner. The social capital is undermined by drawing upon the resources of their own households and their neighbours (in urban areas, such social capital is already weaker). This means that an increased percentage of households in the five cities will be impoverished, and increasingly unable to pay all of their bills (including bills for municipal services). Further, it should be remembered that some municipal policies hit affected households particularly hard around the time of AIDS death. Discontinuation of water and electricity supplies, for example, may hit households at a time that they are coping, economically and emotionally, with an AIDS death and, often, the rapid health decline of the partner. Innovative mechanisms should be put into place to help households cope with this time of particular stress, most effectively by working with community-based organisations and support groups targeting those with HIV/AIDS.

In both cases, HIV/AIDS makes investment in the five localities (and for Namibia as a whole, for that matter) less attractive. Industries that rely on cheap labour and those that rely on skilled or semi-skilled well-paid labour will both be severely affected, undermining profitability. For industries that

have come to Namibia specifically to seek low-cost labour, investment decisions that involve internationally competitive enterprises (e.g., textiles) may be negative. Namibia may need to accelerate the process of importing skilled labour, as many high-growth countries have done and done quite successfully, to overcome this limitation.

Regarding services, the sanitation, sewerage and water services are run on a policy of cost recovery. Thus, the level of demand for these services may be affected by the performance of the economy, and also by the slowed growth rate of the city although, at the household level, ability to pay may be compromised. Electricity provision is, however, different. Electricity is purchased by the municipalities (with the exception of Oshakati and Ongwediva, who are shareholders in the urban distribution companies) and sold at a premium to consumers. It is likely that electricity sales are related to the performance of the regional economy. Any factor depressing the growth of the economy will also depress the demand for electricity and therefore the revenue of the municipality. Ability to pay for electricity at the household level also becomes an issue.

Equally, the sale of land and houses is an important source of revenue for the municipalities. HIV/AIDS will affect these sales in a number of ways, complicating the achievement of delivery targets and interfering with revenue flows. If land or property is purchased from the municipality with no financial ties between the buyer and the municipality existing after the sale, there will be little impact as a result of the epidemic. One possible exception is that house and land prices and the health of the market will be affected by HIV/AIDS via the epidemic's impact on the local and regional economy.

A related and important issue is the impact on revenue growth. All the major sources of revenue are dependent on the size of the city, in terms of area and population. In the demographic section of this report the slowing in the rate of population growth was discussed. This slowing in population growths translates into a reduction in the rate of revenue growth.

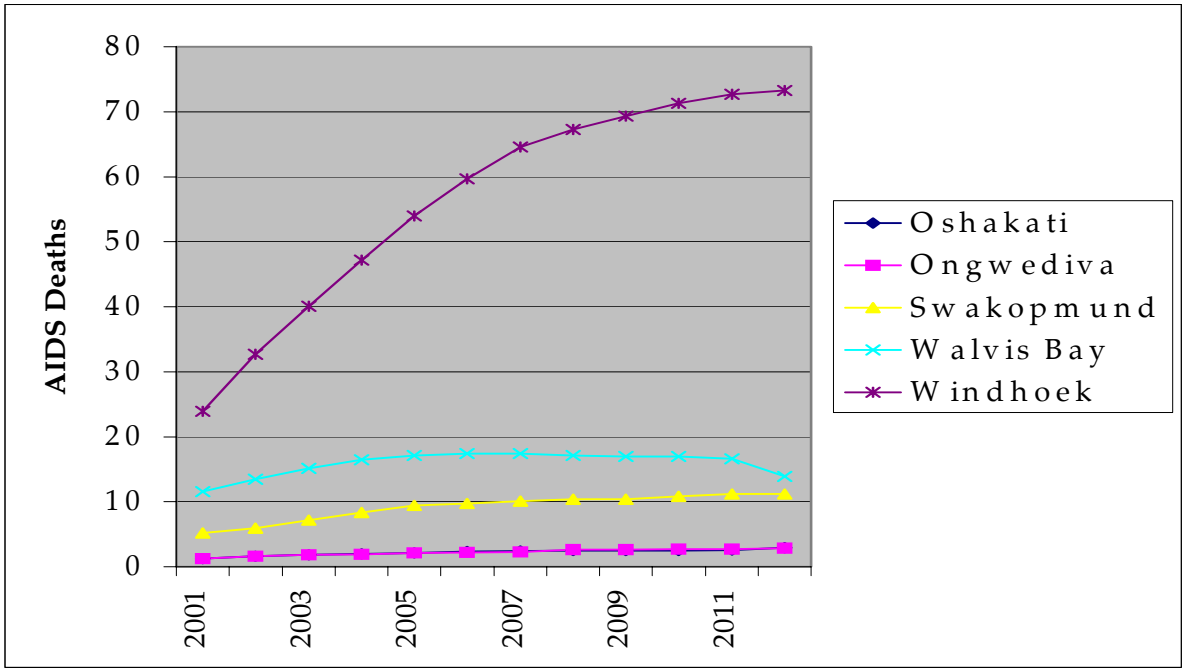
The HIV/AIDS epidemic will impact not only on the revenue of the municipality, but also on the level and pattern of expenditures. Firstly the council is a large employer and is therefore experiencing the associated increasing cost of labour. The magnitude and implications of these increasing costs are discussed elsewhere in this report. Clearly, however, they will increase the expenditure of the municipality while generating no increase in revenue or provision of services.

Finding 6:	Local authorities will lose personnel to the epidemic. The full impact of these AIDS deaths will begun to be felt by 2008-2010.

The municipalities and councils are not themselves immune to the impact of HIV/AIDS. HIV infection and AIDS illness and death among employees through 2010 will result in increased personnel costs, productivity losses and staff turnover. Less easily quantifiable are the disease's impacts on staff morale, the loss of institutional memory and the identification of critical posts.

The full impact of AIDS on the municipalities is only likely to be felt by between 2008 and 2010 when the numbers of those falling ill and dying will reflect the currently high prevalence rates in each city. Unfortunately this means that the responses to AIDS may not seem of immediate concern to all parties that the municipalities must rely on to effect changes and respond effectively to the epidemic. The following figure shows projected AIDS deaths for the five cities over the period 2001-2012. (An eleven-year projection period was used, based on the assumption that the rapid implementation of prevention activities and programmes supporting those who are infected will reduce the death rate after 2012.)

Figure 3.5: Projected Annual AIDS Deaths among Local Authority Personnel, 2001 - 2012



Sick Leave

Sick leave among municipal personnel in the five local authorities is already increasing, without any substantial changes in staff numbers, as illustrated in Table 3.2 below.

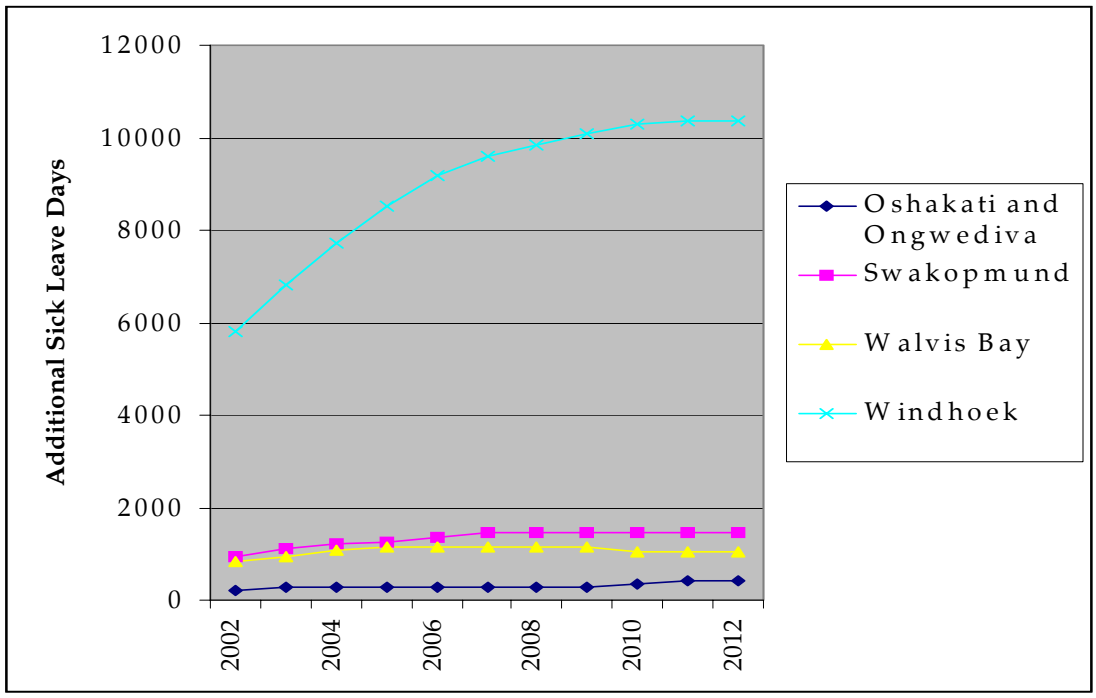
Table 3.2: Reported Sick Leave Days (1999 - 2001)

Municipality	1999	2000	2001
Ongwediva	23	66	159
Oshakati	79	175	107
Swakopmund	2209	2663	3925
Walvis Bay	na	2326	3084
Windhoek	12491	14735	15222
Total	16801	21965	24498

na = not available

HIV/AIDS will accelerate the amount of sick leave taken. Analysis of the data provided by the municipalities as well as the projections indicate that leave taken by infected employees will increase substantially, and indeed already has. This is illustrated in Figure 3.6 below. It should be noted, however, that the seeming drop in Oshakati from 2000 to 2001 is an artefact of the fact that staff were transferred out of the Town Council's engineering department. This suggests that some of these internal impacts can be externalised, and costed in the provision of outsourced services by the private sector.

Figure 3.6: Projected Sick Leave Resulting from AIDS, 2001 - 2012



Finding 7:	The epidemic will result in increases of between 1% and 2% per annum of annual payroll costs simply due to HIV/AIDS. It should be noted that this is a conservative estimate.

The present value cost of the epidemic over the period 2002 - 2010 was calculated for four of the participating cities. (Oshakati declined to make personnel costs and benefit data available on the grounds of confidentiality. Therefore, the consultants were unable to complete cost projections for this local authority.)

These costs are based on losses arising from AIDS-related absenteeism as sick leave and compassionate leave increase, productivity declines, with a resultant increase in training and recruitment costs. These range between 1% and 2% of the annual wages and benefits costs depending on the local authority concerned, and are presented in Table 3.3 below.

Table 3.3: Increased Personnel Costs Resulting from AIDS (2002 - 2010) (N$)

	2002	2003	2004	2005	2006	2007	2008	2009	2010
Ongwediva	65,749	62,805	59,963	57,192	54,510	64,604	70,107	66,744	63,556
Oshakati	na	na	na	na	na	na	na	na	na
Swakopmund	378,901	408,595	415,550	409,480	410,995	412,860	393,199	374,277	356,353
Walvis Bay	387,738	427,033	459,968	467,352	448,014	426,233	405,365	364,164	306,869
Windhoek	2,500,912	2,755,402	2,934,346	3,063,573	3,143,345	3,129,448	3,051,353	2,962,526	2,866,091

na = not available

It should be noted that these costs could be significantly offset by the implementation of an active voluntary counselling and testing programme coupled with the provision of anti-retrovirals. If this were to be considered, the municipalities would want to consider how the costs associated with such provision would offset the loss of their personnel.

Chapter 4: Conclusions and Lessons Learned

Introduction

In this chapter, lessons learned are drawn from the process of assessing impacts for the five municipalities. Lessons learned are related to four arenas:

- The role and potential of Impact Assessments in supporting an informed HIV/AIDS response in the five municipalities and, when properly scaled, in supporting an informed HIV/AIDS response in other municipalities and local authorities in Namibia and outside.
- An informed, comprehensive local response to HIV/AIDS is essential for the success of national and regional responses to HIV/AIDS.
- For an effective 'external' response covering the people the municipalities serve, data gathering and utilisation are key.
- Political commitment is central to effective planning and implementation. Without such commitment, the resources devoted to a proper Impact Assessment, planning, and local response approach to HIV/AIDS will be largely wasted.

The Benefits of the Process

Lessons Learned 1:	The participatory process of Impact Assessment, planning, and local response has resulted in the development of informed, action-oriented plans that are backed by motivated municipal/town councils and local authority personnel. In some cases the approach can be replicated, but in many others consideration needs to be given to responses that are scaled to the situation facing a particular local authority.

The process of involving key municipal personnel in the Impact Assessment process has resulted in municipal/town action plans that are clearly owned by the local authorities, with buy-in across all key divisions and actors within these authorities. The final product of the Impact Assessment process was the production of implementable, realistic and properly-targeted plans. However, the importance of the plans is not that they exist -- HIV/AIDS response plans often do. The difference is that the plans were prepared after a process of detailed introspection and review of the actual impacts of HIV/AIDS, and the projection of impacts, that resulted in widespread buy-in and recognition of the importance of responding to the epidemic. Plan development was therefore informed by the Impact Assessment process, not just by pre-existing information on possible responses. It is therefore an informed response.

Key aspects of the process that supported buy-in included the following:

- Start-up workshop where points of vulnerability to HIV/AIDS were identified, and needed sources of information listed.
- Working with relevant local authority officials to explore impacts on sick leave, compassionate leave, early retirement, benefit distribution, replacement personnel, critical post identification, etc.
- Assessment of the knowledge and attitudes of municipal/town personnel, across grades, regarding HIV/AIDS.
- Determination of the composition of municipal/town staff, and projecting the impacts of HIV/AIDS on this population.
- Establishment of the economic and social base of the various municipal/town areas, and consideration of the demographic, social, and economic impacts of HIV/AIDS on these populations.
- Mainstreaming workshop upon completion of the draft reports to consider the issues identified and convert this to a planned, informed response.
- Follow-up support to municipal/town councils.

The Impact Assessment process essentially identifies weaknesses in structures and conditions which HIV/AIDS exploits, and looks for ways to counter these.

Overall, the process of Impact Assessment enabled those leading the effort in the various municipalities to build a coalition behind the response involving most, if not all, major actors in the municipalities. In this respect the process was as important as the outputs. In those cases where such a broad coalition was built (Walvis Bay, Swakopmund, Windhoek, and Ongwediva), this strongly added to the value of the emergent plan. In the single case where buy-in was compromised (Oshakati), this weakened the value of the exercise. Oshakati first has to overcome this problem in order to establish an effective response to HIV/AIDS (political commitment is discussed later).

Finally, one clear outcome of the Impact Assessment process has been the need to offer over-time technical support to the participating municipalities. While some additional monies were available towards the end of the project due to exchange rate fluctuations affecting the amount available for technical support, funds were inadequate for a proper long-term response. Such support is instrumental in supporting the momentum emergent from the Impact Assessment process.

Overall, therefore, a clear outcome of the Impact Assessment process is that it offers an excellent tool from which a proper response can be formulated within the context of an approach that encourages informed implementation. This can only occur, however, if there is political leadership and support at the local level. When this is lacking, the process of Impact Assessment is considerably undermined.

This is not to say that a single approach should be applied to multiple local authorities, however, Local authorities in Namibia and elsewhere in the Southern African Development Community (SADC) region vary in size, structure, competency and complexity, and vary enormously with regard to the populations they serve (size, composition, economic base, social structures, tax base, etc.). When considering lessons learned, therefore, attention needs to be devoted to making the scale and nature of the Impact Assessment process appropriate for the local authority. Small towns with high squatter populations, such as those in many commercial farming areas in southern and central Namibia, need a different approach than larger towns with a revenue base (e.g., Otjiwarongo, Gobabis, Tsumeb, etc.).

There is also a need to think creatively about how lessons learned from previous Impact Assessments can inform the responses of other communities. NALAO has already identified such cross-learning as an important element of expanding local authority response, and much can be done through NALAO. Other, bi-lateral support initiatives would also support an expanded response, including twinning larger municipalities with smaller ones, 'grouped' planning that involves smaller town councils to learn from the detailed planning activities of larger municipalities, etc. More specifically, in future Impact Assessments, it might be best to consider whether future interested local authorities might be brought into the previous set of Impact Assessment so that they can begin to learn from the process and prepare their colleagues, building a support base as they do so.

To support effective local response, there is a need to build capacity to support these Impact Assessments in a local organisation. This is particularly important in respect to offering over time support. AMICAALL is perhaps best placed to provide such support, especially if it is involved in the next round of Impact Assessments, and particularly if it works closely with NALAO. This would reduce the need for outside technical assistance over the long-term.

An Integrated Response

Lessons Learned 2:	With an effective local response, national and regional initiatives will be substantially stronger. Only with local authority involvement and an informed local response, will Namibia be able to deal effectively with HIV/AIDS, consistent with the Medium Term Plan II (1999-2004) and National Development Plan 2 (2001-2006).

Much attention has been devoted in Namibia's Medium-Term Plan II for HIV/AIDS (1999-2004) to the need for a multi-sectoral response that involves groups at all levels. What is missing, however, from the national and regional response is proper and practical recognition of the key role that local authorities, and local initiatives, can play in such a response. Key stakeholders within and across municipalities, working together, can learn from each other and receive more support from local authorities and local firms, supported from above. 'Scaling across' is, in short, key to scaling up. This requires that municipal and town authorities, as well as other local authorities, play a more aggressive and active role in the HIV/AIDS response. With a properly-scaled Impact Assessment, planning and local response approach which supports extensive 'buy-in', these authorities will be in an excellent position to take on this role.

Data for Effective Planning

Lessons Learned 3:	One lesson learned from the Impact Assessment process was that much is not known about the populations served by the municipal/town authorities. This lack of basic data severely hampers effective planning.

One clear lesson learned from the Impact Assessment process is that key data on a wide variety of issues is severely lacking in virtually all local authority areas. Required data that were not available included, but were not limited to, the following: demographic structure; reproductive health; sexual knowledge attitudes and practices; socio-economic status; business composition, policies on HIV/AIDS, etc.; economic base; social pathologies; population growth trends; etc. When data were available, they were often out of date. Unfortunately this is the result of a process of data collection that is reliant on the particular needs of a particular sector at a particular time, and rarely results in the collection of broad data that would be required for effective, multi-sectoral planning.

This can be overcome by the implementation of a rigorous set of household and business surveys across municipalities/towns, and collecting these data on a regular basis. Such data would be effective for HIV/AIDS planning, but also for planning a wide variety of municipal/town services.

Some of the required data are already collected by local authorities for other purposes (such as business registration), but are not compiled systematically or do not contain all relevant data. Municipalities should therefore consider where they do collect data, and how they can improve these data collection activities and make use of this information for a broad range of planning issues, including HIV/AIDS response.

Overall, there is a need for the municipalities to set up user friendly, short and accessible databases for monitoring purposes. If these systems are established in a way that encourages their use as part of a 'continuous assessment' approach to implementation, commitment to the collection of monitoring data will likely be quite sound. Any technical assistance sought for establishing monitoring systems for an effective HIV/AIDS response, therefore, needs to be grounded in the specific needs of the local authorities themselves.

Political Commitment

Lessons Learned 4:	Political commitment is central to the success of any HIV/AIDS response. Few initiatives, if any, can survive without high profile, over time, commitment.

The Impact Assessment process has highlighted the importance of political commitment to an effective HIV/AIDS response. Commitment by high-level municipal officers played a crucial role during the Impact Assessment process through involving municipal councils, motivating municipal staff and bringing stakeholders together.

Without political commitment, it is unlikely that even 'best practice' procedures will have any impact. Leadership at the local authority level helps to ensure vision, supports effective advocacy, and motivates the various parties needing to respond to actually do so. Of course, political commitment is not something that always automatically happens, and it is by no means assured that it will always be there. In particular, when key individuals are replaced, and the new person is not fully committed to an HIV/AIDS response, initiatives fail. There is therefore a need to entrench the commitment in the political office, rather than in the political officer, and to institutionalise mechanisms for high-level political commitment.

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